**Missouri Department of Health and Senior Services**
P.O. Box 570, Jefferson City, MO 65102-0570

Missouri Department of Health and Senior Services

# DESK REVIEW AND ASSURANCE AGREEMENT FOR COMPLIANCE WITH STATE AND FEDERAL CIVIL RIGHTS LAWS AND REGULATIONS

The following questionnaire is designed to assist in determining your facility's status of compliance with Titles VI & VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; Age Discrimination in Employment Act of 1967; Age Discrimination Act of 1975, as amended; Sections 503 and 504 of the Rehabilitation Act of 1973; Omnibus Budget Reconciliation Act of 1981; Title IX, Health Services and Facilities, Section 190B, (2); Americans with Disabilities Act of 1990; Civil Rights Act of 1991; Chapter 213 of the Revised Statutes of Missouri, as amended; and this rule.

**Please complete this form (type or print) and return within 30 days from the date of receipt to:**

Department of Health and Senior Services
Office of Personnel/Civil Rights Compliance Coordinator
P.O. Box 570
Jefferson City, MO 65102-0570 (573) 751-6056 or 751-6059

## SECTION A – General Information (additional sheets may be attached for answers)

Provider Name | Type of Service(s) Provided | Telephone | Date of Review

Address (Where provider has face-to-face contact with patients/clients) City, State, Zip, County

Group/Corporation Name (if applicable) **NOTE: If your group/corporation has service providers in more than one office/facility, each office/facility must be evaluated for compliance.**

Address City State Zip County

1. Has your office/facility ever been evaluated for civil rights compliance by the federal Dept. of Health and Human Services/Office for Civil Rights, MO Dept. of Social Services, or the MO Dept. of Health and Senior Services? (NOTE: this would include previous completion of a DHSS Desk Review form or any other DHSS Civil Rights Program Compliance form.) **No _____ Yes _____**

   **If yes,** you must complete the name/address information above, sign the last page of this form, and attach a copy of the HHS/OCR, DSS, or DHSS letter/form that states you are in compliance, and submit this form without completing the remaining questions. **If no,** please complete the entire form.

2. Does the facility have a written non-discrimination policy statement displayed in a location where the public can see it? **Please attach a copy. Yes ____ No ____ (Sample language is provided.)**

3. Does your facility have a DHSS Non-Discrimination Policy Statement posted in clear visibility of all persons entering the facility? **Yes ____ No ____**

4. All agencies, facilities or programs funded in whole or part with state and/or federal funds must make available to clients and potential clients a Complaint of Discrimination process. What is your procedure and how is it made known to your clients? **Please attach a copy of your procedure. (Sample language is provided.)**

5. Your facility is required to maintain statistical data on race/ethnicity on all participating clients or rejected clients. If DHSS conducts an on-site compliance review, will all relevant records be available on site? **Yes ____ No ____ If no, where are the records located? _____**
   **_____**

   - Please describe method used to collect this information: _____

## SECTION B - Office/Facility Accessibility

6. Is your facility accessible to and usable by persons with disabilities in the following areas**? (Standards set forth in the Americans with Disabilities Accessibility Guidelines must be followed.)**

| | |
|---|---|
| Parking | **Yes ____ No ____** |
| Entrances | **Yes ____ No ____** |
| Waiting Areas | **Yes ____ No ____** |
| Examination Rooms | **Yes ____ No ____** |
| Restrooms | **Yes ____ No ____** |
| Telephones | **Yes ____ No ____** |
| (Where public telephones are available.) | |
| Drinking Fountains | **Yes ____ No ____** |
| (Where public drinking fountains are available.) | |
| Elevators | **Yes ____ No ____** |

7. Are all program activities available to persons with disabilities? **Yes ____ No ____** If not, what arrangements have been made to ensure their participation?

## SECTION C – Services Accessibility

8. Are all clients/employees of the facility made aware of the policy of non-discrimination in the provision of services? **Yes ____ No ____** Are employees provided Non-Discrimination in Provision of Services Training and Title VI Civil Rights training? **Yes ____ No ____** If not, how are employees of the facility made aware of this policy and other civil rights requirements?

9. Providers with fewer than 15 employees may refer people with disabilities to an accessible provider only if the required changes to make the facility accessible would involve fundamental alterations in the nature of the agency's program(s) or undue financial or administrative burdens. Therefore, if you are referring clients to other providers you must notify them in writing, and receive assurance in writing, that all services offered must be executed in a non-discriminatory manner. **If applicable, please provide a copy of the assurance letter.**

10. Do you or your facility/agency enter into contractual or other agreements with "out-of-institution" providers? If yes, have you required, in writing, an assurance that their programs and services are provided on a non-discriminatory basis without regard to race, color, national origin, sex, age, religion, political beliefs, or disability? **Yes ____ No ____ Please attach a copy.**

11. Do you or your agency provide home visits as a part of the services extended to persons with disabilities? **Yes ____ No ____**

12. Are qualified interpreters and translated materials made available for persons with Limited English Proficiency (LEP)? **Yes _____ No _____**

13. To ensure services are provided to people with communication problems and disabilities (such as hearing, speech, visual, and mental impairments) arrangements must be made to ensure the availability of needed assistance. Examples are: Telephone handset amplifiers, readers, cassette recordings or Braille material. Have you made such arrangements? **Yes ____ No ____** Has your staff been informed of any/all auxiliary aids that are available for services to persons with disabilities? **Yes ____ No ____ Explain how staff are advised of this information and trained to assist in the usage of the aids.**

14. Are assistive devises available on-site or through other resources? **Yes ____ No ____**

15. Have you included persons with disabilities and/or other minorities and women on any committees, advisory or planning boards? **Yes ____ No ____**

16. If you provide services to children, is your facility smoke free? **Yes ____ No ____**

17. Are client application procedures for programs or services void of screening practices, which would allow for any discrimination against persons with disabilities? **Yes ____ No ____**

18. When assessing a person's eligibility for your programs and/or services, do you use the same procedure for all persons without regard to race, color, national origin, sex, age, religion and/or disability? **Yes ____ No ____**

## SECTION D - Organizational Data

19. Has the facility ever been the subject of a compliance review by a federal agency?
**No ____ Yes ____ When? _____** If yes, what was the disposition?

20. Are you an employer of 15 or more persons? **Yes ____ No ____** If yes, what steps have you taken to notify participants, beneficiaries, applicants and employees that you do not discriminate on the basis of race, color, national origin, sex, age, religion and/or disability? What steps have you taken to encourage participation in your programs?

    - Does your agency have a designated civil rights coordinator? **Yes _____ No _____**
    - Name and phone number of coordinator: _____

21. Each covered recipient agency shall print in easily read type on all public program communications this or similar statement: "Eligibility criteria for acceptance and participating in this program are administered on a nondiscriminatory basis regardless of race, color, national origin, age, sex, or disability." Do you do this? **Yes _____ No _____**

22. Are all employment decisions made by your agency made on merit? **Yes ____ No ____**

23. Does your agency have and maintain a personnel merit system? **Yes _____ No _____**

24. Do you have written non-discrimination/ personnel policies? **Yes _____ No _____ (Please attach copies.)**

25. Total number of persons employed by your agency: African-American _____ Caucasian _____ Hispanic or Latino _____ Asian _____ Native Hawaiian or Pacific Islander _____ American Indian or Alaska Native _____ Bi or Multi-Racial _____

26. Type of agency. (Please check one)

- ! Private (Non-government: **NOT** local, state or federal)
- ! Public (Government: local, state or federal)

27. Are you an employer of 50 or more persons? **Yes _____ No _____**

- ! Do you implement an affirmative action program that complies with the civil rights requirements? **Yes _____ No _____**

28. What forms of communication are used to provide information to the general public about your programs and services?

| | |
|---|---|
| Program Brochures | **Yes** ____ **No** ____ |
| Letterhead | **Yes** ____ **No** ____ |
| Public Notice | **Yes** ____ **No** ____ |

Other _____

29. Does your facility inform "grass roots" organizations (churches, service clubs, etc.) about your programs and services? **Yes** ____ **No** ____

## SECTION E - Technical Assistance

The Missouri Department of Health and Senior Services can offer technical assistance.

1. Have you requested any technical assistance related to Title VI or any other Civil Rights statutes covered by this document from the Missouri Department of Health and Senior Services (DHSS)?

   **Yes** ____ **No** ____

2. Do you need information on what posters are needed for compliance and how to get the posters?

   **Yes** ____ **No** ____

3. Do you need a copy of the DHSS Non-Discrimination Policy Statement?

   **Yes** ____ **No** ____ **Quantity needed:** _____

4. Do you need information on available training and how to conduct in-house training on civil rights issues?

   **Yes** ____ **No** ____

## Section F – Signature

**Name, title, and telephone number of the person who completed this form:**

_____

_____

**I certify that the information given is true and correct to the best of my knowledge and belief.**

_____

**Signature of Agency Administrator/Director/Provider** **Title** **Date**

***DO NOT WRITE BELOW THIS LINE * * * DEPARTMENT USE ONLY***

| Date Sent Out | Date of Return | Compliance Letter Date |
|---|---|---|

| ! Concerns | ! Letter to Notify | ! Non-Compliance Issues Addressed |
|---|---|---|